Service to the poor: The foundations of community nursing in England, Ireland and New South Wales

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This paper describes the foundations of community nursing in England, Ireland and New South Wales. It is guided by Foucault’s work on power, discourse and knowledge, and argues that the common discourse of poverty coupled with the influence of socially advantaged women in the nineteenth century was the impetus for the development of community nursing in England, Ireland and New South Wales. Throughout the nineteenth century in Great Britain, economic and industrial development, coupled with an unprecedented growth in the population (particularly among the poor) inspired socially advantaged women to extend traditional gender-specific roles to address the needs of the poor. Protestant women in England advanced professional nursing as a career for women and in Ireland and New South Wales; Catholic women pioneered professional nursing, targeting the poor as the focus of their practice. These women used prevailing social conditions to enhance their life options within the limits prescribed by social norms.

Key words: Catholicism, community nursing, England, Ireland, New South Wales, poverty, Protestantism.

LIVING IN POVERTY

In the nineteenth century, Britain emerged from a predominantly rural society to become an industrial society that expanded its boundaries to influence and shape the history of many other cultures in the world. The peace that Britain and her dominions experienced following the Napoleonic wars facilitated a period of prosperity, growth and expansion. Britain became a sovereign nation, extending her influence throughout the far corners of the globe. However, prosperity did not reach all levels of society. Industrialization, growth and expansion of the economy following the Napoleonic Wars came at a price for some within British society. Many rural and cottage industry workers were displaced by the modernization of industry, improvements in agricultural practices, increasing non-profitability of farming on a small scale, and the closure of common lands by the State, which resulted in the loss of traditional incomes and ways of life. For many people, poverty became a way of life, although McCord cautions that living in poverty was not a new experience but an age-old problem.

PHILANTHROPY: THE TRADITIONAL ROLE OF THE CHURCH

Traditionally in the UK, the poor and infirm had been cared for by religious people from the Roman Catholic
The sick were cared for within the monasteries and nunneries by religious men and women, or were visited in their homes by the religious and also by women of the gentry as tradition decreed. Visitation of the sick allowed religious people access to homes, and was a strategy of surveillance to monitor the behaviours of the congregation. Following the dissolution of the Roman Catholic monasteries during the reign of Henry VIII, provision for the poor and infirm was neglected.

The injury inflicted upon the whole system of Catholic charities by the upheaval of the sixteenth century was disastrous in many ways to the work of the Hospitals. The dissolution of the monasteries, especially in England, deprived the Church, in large measure, of the means to support the sick and of the organisation through which those means had been employed (Walsh; stated in Murphy, p. 2).

The closure of the monasteries, the cessation of social welfare and the subsequent rise in pauperism led Elizabeth I to legislate the Poor Laws. Under the Poor Laws, assistance was provided in two forms: (i) outdoor relief, where recipients were provided with money, food and medical care in their homes; and (ii) indoor relief. Indoor relief required recipients to be placed in an abode set aside for the impoverished. The Protestant Church of England saw philanthropy or charitable activity as a religious duty. However, the poor were viewed with suspicion by the wider society, which encouraged industry and production not idleness.

Foucault explanation is that society adopts belief systems that function as forms of power by subjectifying individuals as objects. Subjectification implies that a power relationship exists, which Foucault argues is relational to knowledge. Knowledge and power, he claims, serve to authorize bodies or to subjugate the subjectified body. Foucault suggests the body is largely a force of production invested:

... with relations of power and domination; but, on the other hand, its constitution as labour is possible only if it is caught up in a system of subjection (in which need is also a political instrument meticulously prepared, calculated and used); the body became a useful force only if it is both a productive body and a subjected body (p. 26).

The subjectified body is useful only as far as it is productive. Therefore, the poor, who were unable to find employment, appeared to be stigmatized by nineteenth century English society as unproductive. Therefore, they were viewed as a burden on the State.

TRADITIONAL WOMEN’S ROLES AND THE GROWTH OF FEMINISM

British society valued women for their reproductive ability and believed that women were intellectually and physically inferior to men. Women were encouraged to be docile, self-sacrificing, obedient and pure. If women did not conform to this stereotype they were reviled as amoral. Traditionally, middle class women were educated by their mothers, grandmothers and aunts to become dutiful wives, who upon marriage relinquished ownership of any lands or wealth they may have possessed to their husbands. As wives, middle class women were expected to nurture children, to provide their husbands and children with moral guidance and to assist in the moral development of the socially inferior. Middle class women were not expected to work in paid employment, but were encouraged by society and religious tradition to engage in charitable activity directed at changing the behaviours of the working classes. Working class women were considered by their social superiors to be ‘morally suspect’.

NIGHTINGALE AND PROFESSIONAL NURSING

Florence Nightingale emerged in the early nineteenth century as an advocate for the professionalization of nursing and, inadvertently, for women’s enfranchisement. Nightingale was not predisposed to marriage and recognized an opportunity to advance career options for socially advantaged women. She admired the work of the Catholic religious women nurses and spent time with a Protestant order of Deaconesses in Kaiserswerth, Germany, studying nursing. With the outbreak of the Crimean War, Nightingale advocated for professional nurses to accompany the British soldiers to war. She argued that trained nurses, who were Catholic, supported the French army. These nurses, she asserted, reduced the morbidity and mortality of men engaged in the war because of their nursing skills. Nightingale’s testament to the expertise of the French Catholic women, coupled with Britain’s dependence on the working classes for economic productivity and the presumed threat ill health and immorality among the poor posed for the socially advantaged of society and national security, provided...
the impetus for women to challenge traditional gender roles.  

**THE EMERGENCE OF HEALTH VISITING AND DISTRICT NURSING: STRATEGIES TO DEAL WITH THE POOR**

As Britain’s population increased, particularly among the working classes, so did the demands on the State for health and welfare assistance. Outdoor assistance was limited from 1834, thus providing some relief on the Poor Laws, and increasing assistance was provided on an indoor basis. The State stipulated that work-houses should not be attractive options for the poor, therefore the poor were dissuaded from accessing the facilities by making life within them difficult. This attitude was supported by a coexistent philosophy that supported the notion that industry and productivity were ordained by God, and, conversely, that idleness was sinful.

During the nineteenth century, there were more middle class single women than men. This phenomenon, coupled with society’s view of femininity, led socially advantaged women to explore socially endorsed alternatives to marriage. Activities such as home nursing of the poor were popular and advocated by societies of women. The main proponents were Elizabeth Fry’s Protestant Nursing Sisters, the Gloucester District Nursing Society and the Ranyard Missionary Ladies. Their work was in keeping with society’s view of what was acceptable feminine behaviour for women and also assisted the State to monitor and influence the behaviour of the poor. In 1859, William Rathbone employed Mary Robinson to work among the poor in Liverpool, England. Dingwall et al. suggest that Rathbone was the first person to use the term ‘district nursing’. Although his scheme was not new, it was innovative because he recognized the need for district nurses to be trained nurses, which was a position supported by Nightingale who stated that the district nurse must ‘... be of a yet higher class and of a yet fuller training than a Hospital nurse ...’

Nightingale believed that district nurses should be more highly trained than hospital nurses because their practice occurred outside the controlled environment of hospitals; a view that Rathbone accepted. In 1887, Queen Victoria supported the establishment of the Queen Victoria Jubilee Institute for Nurses, which was chaired by Rathbone and followed the model he had developed. The Queen’s Nurses as they became known, were recruited from groups of women who had completed a nurse training course in an approved hospital. Once employed, the nurses completed an additional training period in a District Nursing Association in district nursing.

In addition to the various home nursing organizations, women’s societies were formed to teach working class women about domestic hygiene and child health. It was argued that if working class women accepted middle class values, then the threat posed by the immorality of the poor would be addressed. Moreover, concern about national security in the wake of the Crimean War prompted authorities to consider the health of the working classes. Health visitors were engaged to monitor sanitary living conditions and to educate working class women on domestic hygiene and child nurturing, activities that were accepted by society because they maintained a veneer of femininity. Eventually, health visitors were expected to be trained nurses, and hold a qualification in sanitation and either midwifery or obstetric certificates. Therefore, district nursing and health visiting became specializations within nursing; a development supported by educated women who sought avenues for career advancement that guaranteed influence and respect.

**IRISH CATHOLICISM AND THE POOR**

The Catholic Church in Ireland, like England, was sacked under Henry VIII and outlawed. Catholicism was renounced by the crown and the Protestant Church of Ireland was declared the ‘true’ church of Ireland. While England accepted the loss of Catholicism and embraced Protestantism, in Ireland Catholicism continued to be practised by the majority of the population. The British Crown attempted to break the hold of the Catholic Church in Ireland and passed a series of laws, the Penal Codes (1703), which outlawed Catholicism, the clergy, and prevented Catholics from owning land, thus prohibiting Catholics from participating in political life. The work of the Catholic clergy and the religious orders in Ireland continued, with many new religious orders emerging to deal with the plight of the poor in the wake of the devastation caused by the industrial revolution and England’s demands on Ireland following the Napoleonic Wars.

**IRISH CATHOLICISM AND FEMINISM**

Women within Catholic society, like their Protestant English counterparts, were encouraged to make successful marriages and to produce and nurture children. However, Irish middle class Catholic women were better
educated than their Protestant English counterparts. Many Irish Catholic women were sent abroad to study in the Catholic countries of France, Spain and Italy. Irish Catholic middle class women who chose not to marry had the added option of taking religious vows, which was socially acceptable and openly encouraged by Catholic families and the Catholic Church.

For Catholic women there was opportunity within the framework of religious orders to aspire to and achieve positions of power within the congregation and the wider society. However, because the Catholic Church is based on a patriarchal structure, religious women had to adhere to conditions determined by the Church.

Throughout the nineteenth century, the number of socially advantaged Catholic women joining religious congregations increased. New orders of religious women were founded, which modelled congregational rules on innovative practices that permitted religious women to participate in society. Uncloistered religious women commanded respect and were influential within society. Moreover, these women were well received by the Church, which needed assistance to support the increasing numbers of poor, and nursing and education of the poor were identified as appropriate apostolates of care.

CATHOLIC RELIGIOUS WOMEN

The Irish Sisters of Charity founded by Mary Aikenhead in 1815, and the Sisters of Mercy founded by Catherine McAuley in 1827, discarded their lives in the cloisters to live and work among the poor. Both these orders undertook nursing and teaching as strategies to enhance the lives of the poor as well as to expand their own career options. As religious women, they were bound by their vows, including poverty, chastity and obedience; however, as Eckenstein argues, religious women were able to aspire to and achieve positions of influence within the congregation and were respected by the society.

RELIGIOUS WOMEN SERVE THE POOR AND THE STATE

As in Britain, advances in agricultural practices and industrialization impacted on traditional ways of life. People moved from rural areas to the cities seeking employment; consequently, the numbers of urban poor increased. In Ireland, the State introduced the work-house system in 1838 to provide in-house relief to the aged, frail, orphaned and sick. In addition, Catholic religious women established health services that included home visiting and the founding of hospitals, hospices, orphanages and schools for the education of girls and women. Catholic religious women were accepted by the Irish poor because they were Irish and willing to work and live among them.

From 1832, Ireland was ravaged by plagues of cholera. The Catholic poor of Ireland were distrustful of the Anglo-Irish authorities and refused to be admitted to the State voluntary hospitals. The authorities realized that the plague could only be controlled if victims were isolated. Catholic religious women assisted the State by encouraging the poor to go to hospital and volunteered to nurse the sick in the State hospitals.

Unlike hospital nurses who were illiterate, untrained and working class, Catholic religious women were educated 'ladies' accepted by the Catholic poor because they were religious women who were willing to work and live among them.

PROFESSIONAL NURSING AND MEDICAL PROFESSIONALIZATION IN IRELAND

The large numbers of people affected by the cholera plagues and concerns that the spiritual needs of Catholics were not being met in the voluntary Hospitals led Mary Aikenhead to found the first Catholic hospital, St Vincent’s in Dublin in 1834. Mary Aikenhead sent three of her nuns to France to train as nurse-apothecaries and hospital managers. She advanced the idea that trained nurses were required to provide skilled care, a notion that Florence Nightingale was also beginning to contemplate in England. To guarantee medical treatment of the hospitalized poor, Aikenhead appointed honorary surgeons and physicians to St Vincent’s. Honorary medical appointments were sought as they provided medical practitioners with income in a market over-supplied by medical practitioners, and allowed medicine the opportunity of advancing knowledge through the study of diseases processes. Following the establishment of the first Catholic University in Ireland in 1858, Aikenhead consented to a Clinical School of Medicine being established at St Vincent’s in Dublin. The clinical school concept was advocated by medical practitioners as it provided students with an opportunity to study disease and treatment modalities. Moreover, skilled educated religious nuns trained as nurses were supported by the medical profession because they required educated, obedient nurses to monitor patients in their absence and provide treatment as they
directed. The Clinical School of Medicine also guaranteed Aikenhead inexpensive medical support for the poor admitted to the hospital.\textsuperscript{7,15}

In the absence of welfare assistance from the State, and prior to the introduction of the Irish Poor Laws in 1838, Catholic religious women visited the sick in their homes and provided alms to the destitute. The nuns continued their home visitation programmes following the establishment of hospitals, but nursing care was increasingly focused in hospitals because medical assistance was available, spiritual guidance was more easily provided and the patients could be cared for and nourished in environments that the nuns believed promoted wellness.\textsuperscript{7,14}

**TRANSPORTATION: THE PENAL COLONY OF NEW SOUTH WALES**

The swelling population of England and Ireland during the nineteenth century, and the displacement of rural poor to the cities, resulted in a growing population of urban poor. Increased hardships experienced by the urban poor, who were unable to find employment or whose employment returned wages that were insufficient to meet the costs of living, resulted in an associated increase in crime.\textsuperscript{1} British prisons were unable to cope with the number of people incarcerated. America, having declared its independence, refused to accept convicts, and a new method or place for disposal of convicts was sought. New South Wales was identified as a suitable repository for convicted felons with the first fleet arriving in Botany Bay in 1788.\textsuperscript{1,15,16}

As a British colony, Protestantism was the established religion; however, one-third of the population throughout the transportation period was of Irish Catholic heritage. Moreover, men outnumbered women three to one.\textsuperscript{7} Women convicts were regarded by society as ‘damned whores’, an image that was perpetuated throughout the nineteenth century.\textsuperscript{7}

Catholicism was regarded with suspicion by the British authorities because they believed attendance at mass would be used by the Irish to incite sedition.\textsuperscript{17} However, the Irish Catholic Church was permitted, from 1803, to recruit clergymen to undertake service in the colony within strict guidelines established by the colonial authorities.\textsuperscript{7}

**COLONIAL HEALTH CARE**

From humble convict beginnings, the colony of New South Wales expanded and assisted immigration of free settlers secured the success of the colony and added to the burden on the authorities to provide services including health care, welfare, education and housing.\textsuperscript{18} Five colonial surgeons accompanied the first fleet and established the first convict hospital, the Sydney Infirmary. From the beginning of white colonization, the medical profession was able to establish a position of power. The colonial medical officers were members of the colonial militia and also members of a necessary profession with limited numbers of practitioners in a climate with no competition from other health care providers.\textsuperscript{7,19} The colonial surgeons provided medical care to the convicts and the colonial military. Nursing care was provided by convict women and men incapable of being assigned to manual labour because of infirmity, illness or advanced age.\textsuperscript{7,20}

The colonial authorities supported the established church and encouraged philanthropy by the wealthy as a strategy to encourage the colonists to provide assistance to the non-convict members of colonial society. This reduced the financial burden incurred by the introduction of State health and welfare initiatives.\textsuperscript{19,21}

The doctrine of the established church taught that the wealthy were obligated to provide spiritual and physical assistance to members of society considered to be deserving. In addition, the Catholic Church was supported by the colonial authorities to expand, because the church was willing to support the Catholic poor, who otherwise would have been a burden.\textsuperscript{7}

In 1813, the first charitable society, a Protestant philanthropic society, was established by eminent colonial men to teach Protestantism and to provide assistance to the deserving poor. The Benevolent Society of New South Wales, as it was known from 1818, founded an asylum for the destitute, ill, aged, orphaned and pregnant unmarried women. Within the asylum, honorary surgeons provided medical care, while nursing care was provided by able inmates of the asylum. Only limited outdoor relief was provided as the focus of the society’s functions was indoor relief.

For medical officers attempting to establish fee-for-service private practice, appointments as honorariums at the Benevolent Society Asylum, and later at St Vincent’s Catholic Hospital, assisted them to gain a reputation.\textsuperscript{21} The burgeoning of private medical practices was coupled with restrictions on medical practitioners’ time. Therefore, the hospitalization of patients was justified because many of the colonial poor lived in squalid conditions and were poorly nourished, and demands on the medical practi-
tioners’ time for travel to visit patients in their homes was reduced.7,19

CATHOLIC RELIGIOUS WOMEN ADDRESS THE NEEDS OF THE COLONIAL POOR

The Catholic Church was active in providing pastoral care to Catholic convicts from 1798. However, it was not until 1838, under the leadership of Bishop John Bede Polding (the first Catholic Bishop of New South Wales), that the first Catholic women arrived in the colony to expand the Catholic Church’s pastoral programme to include nursing and the education of children and women.

Bishop John Bede Polding acknowledged the poverty in which the Catholics of Sydney lived and recognized a need for trained nurses to care for the poor.13,14 Knowing the work of the Irish Sisters of Charity, he approached Mary Aikenhead who sent a contingent of five religious sisters to New South Wales.7,19

The work undertaken by the Sisters of Charity included the establishment of a school for poor children, the visitation of the sick poor in their homes, working with women prisoners at the Parramatta Infirmary, nursing in the convict Hospitals in Parramatta and Sydney, and the founding of a refuge for single women and an orphanage for Catholic children.7,13,14,21 Throughout the nineteenth century, the numbers of single women with dependants rose. The colonial authorities advocated marriage and provided incentives for men willing to marry; however, women were not well regarded. Therefore, women and children became the focus of the activities of the nuns from the time of their arrival in the colony.14

PIOUS WOMEN AS PROFESSIONAL NURSES ACCEPTED BY COLONIAL SOCIETY

Two of the Sisters of Charity were trained as nurses, were skilled in Hospital management and had apothecary knowledge.2,14 Brodsky notes that Sister M. Baptist de Lacy was regarded by a member of the community as being the only person in the colony qualified to be a matron of a hospital.22 In keeping with the traditions of their religious order, the Sisters of Charity opened St Vincent’s Hospital in Sydney, the first Catholic Hospital in the colony. Unlike the nurses employed in the colonial convict hospitals, who were described as a ‘dissolute class’, the Sisters of Charity were well-educated, middle class Irish women respected by society because of their piety and willingness to work among the poor.7,20,22 As nurses, the nuns were skilled, efficient, educated and obedient, qualities medical practitioners applauded.19

MARGINALIZATION OF COMMUNITY NURSING

From 1838, the Sisters of Charity began a tradition of nursing excellence in New South Wales that focused on providing for the needs of the poor. Miller suggests that the reputation of the sisters as skilled nurses spread throughout the colony.24 Honorary surgeons employed by the State hospitals, perhaps as a result of the reputation of the nuns and exposure to working with skilled nurses while completing post-certification studies in Britain and Europe, demanded the recruitment of professional nurses to staff the hospitals.8

In the absence of other services directed at caring for the poor in their own homes, the Sisters of Charity advanced community nursing practice. However, sustaining the level of assistance required by the colonial poor was difficult for the nuns. Colonial boundaries were expanding, which increased the distances the nuns needed to cover in order to visit the poor in their homes. Moreover, medical support was limited by the numbers of medical practitioners in the colony, the demands on the time of the medical officers in service of the State, private practices and their obligations as honorariums.19–21

Growing concern about meeting the needs of the poor, coupled with the nuns’ inability to attract large numbers of postulants and their belief that the most appropriate place to care for the sick poor was within the controlled environment of a hospital (a view supported by colonial medical practitioners) led the Sisters of Charity to open the first Catholic hospital, St Vincent’s Hospital in Sydney in 1856.14,22,25 The opening of St Vincent’s Hospital was a strategic initiative by the Sisters of Charity. The Sisters found it difficult to recruit postulants so the effectiveness of the services they provided through their pastoral care programme and their voluntary work at the convict hospitals (which were resource intensive) were not sustainable. It was argued that there was little that could be achieved by skilled nursing if the living conditions in which the poor lived were not conducive to wellness.13,22 Therefore, the Sisters of Charity rationalized services, including their home visitation programme, following the opening of St Vincent’s Hospital.

Hospitalization of patients was an effective and efficient means of maximizing the Sisters of Charity’s resources. As
patients of St Vincent's Hospital, the poor were guaranteed medical care from honorary surgeons and received nursing care from trained nurses in an environment that the religious women and medical officers considered favourable to the promotion of health. In addition, the spiritual well-being of patients was more effectively managed as the nuns provided care on a 24-hour a day basis.

**CONCLUSION**

Throughout the nineteenth century in England, Ireland and New South Wales, the poor were identified as a threat to society. In England and Ireland, socially advantaged women used prevailing social conditions to advocate for new roles for women. The poor became the objects of social planning and philanthropic endeavours. In England, health visiting and district nursing emerged as specialist areas of nursing, established to provide women with socially endorsed career options and as mechanisms to manipulate the behaviours of the poor. In Ireland and in New South Wales, Catholic women pioneered professional nursing, within the framework of the male-dominated hierarchical system of the Catholic Church, to meet the needs of the poor. As in England, the Irish poor and the Australian colonial poor were poorly regarded by society and the State. Moreover, as in England, the needs of the poor provided Catholic Irish women with an opportunity to challenge tradition. New orders of Catholic religious women emerged, which accepted the plight of the poor as the basis upon which to found innovative congregations.

Unlike the women of England, Catholic religious women were bound by vows that precluded them from seeking worldly recognition for their activities. As members of a religious community they were obligated to consider the community and the wider congregation at the expense of self. The nuns visited the poor in their homes and nursed the sick in the convict hospitals as required. The poor, medical practitioners and the colonial authorities accepted these Catholic women because they were pious and posed no threat to the position within health care that the medical profession was assuming. As the colony grew and the demands on the nuns to support the poor through their health, welfare and education programmes burgeoned, new approaches to service provision were sought. The opening of St Vincent’s Hospital provided a cost-effective and efficient method of caring for the poor and was accepted by society and the medical officers. Community nursing, which was practised by the nuns, was therefore inadvertently marginalized by religious women who believed care for the poor was qualitatively improved if they were nursed in the controlled environment of a hospital.

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**REFERENCES**

23 Baptist Lacy M Sr *Personal diary held in the archives of the Sisters of Charity*. Potts Point, 1838.
25 Watson JF. *The History of the Sydney Hospital from 1811 to 1911*. Sydney: Gullick, 1911.